Mountain-Pacific Quality Health

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*"The best quality health care is provided to every patient we serve, **every time**."*

Montana Medicaid Prior Authorization Request Form for Use of

Suboxone®, Zubsolv® (buprenorphine/naloxone) or Subutex® (buprenorphine)

Coverage Restricted Exclusively for the Treatment of Opioid Addiction

Providers must submit their **Treatment Plan** before authorization will be considered.

At a minimum the **Treatment Plan** must include the following information:

- Documentation of assessment and screening for opioid dependence (DAST-10, DSM-IV)
- Documentation of opioid substance of abuse
- Documentation of proposed counseling schedule
- Documentation of proposed monitoring plan (urine drug screens, random pill counts, etc.)
- Copy of Controlled Substance/Treatment Contract which must include consequences for failure to comply

(Please note authorization limitations on page 2)

Patient's Name: _____ Date: _____

Patient I. D. Number: _____ D.O.B: _____

Physician's Name :_____

Physician's Phone # _____Physician's Fax Number: _____

Drug/Dose Request: _____ (mg) Daily Directions: _____ (i.e.: 1 QD)

Is patient pregnant or nursing?_____ If Yes, Due Date?_____
(Note: If pregnant, documentation of a positive pregnancy test required to utilize Subutex®)

Signature of Physician: _____

DEA#: X-_____(Prescriber must have an X-DEA Number)

Please complete form, attach documentation and fax to:
Medicaid Drug Prior Authorization Unit
1-800-294-1350

Montana Medicaid
Suboxone®/Subutex/Zubsolv® Authorization Limitations

Covered Condition – Treatment of Opioid Addiction

Subutex®: Approvals will be limited to 5 days to allow for induction in the absence of a pregnancy diagnosis. For pregnancy, Subutex® will be authorized only for the duration of pregnancy or nursing. Documentation of a positive pregnancy test is required at initiation and 4 months of therapy. Maximum dose limitations for Suboxone® will apply.

Suboxone®/Zubsolv®:

- Patient must be 16 years or older.
- **Initial approval will be granted for 2 months. Dosing will be limited to maximum buprenorphine 24 mg/day for Suboxone® film and 17.1 mg/day for Zubsolv®. Requests for doses exceeding this will require provider documentation.**
    1. **Documentation of compliance with counseling, drug screens (including buprenorphine and drugs of abuse), and office visits must be provided for continuation of therapy beyond the initial 2 months of therapy.**
    2. **Review and approval will be required at 4 months of therapy to verify continued patient compliance.**
- After 6 months, approval may be granted for additional 6 month intervals up to 18 months to allow for a total of 24 months of therapy. Dosing will be limited to maximum Suboxone® film 16 mg/day and 11.4 mg/day for Zubsolv®**.**
- Requests for dose increases will require provider documentation.
- Concurrent opioids, tramadol, or carisoprodol will not be covered. If a patient is Prior Authorized for Suboxone®/Subutex®/Zubsolv® after meeting all criteria and subsequently discontinues the medication, all opioids, tramadol formulations, and carisoprodol will remain on not-covered status. These medications will require Prior Authorization for any future prescriptions. Approval may be granted short-term for an acute injury, hospitalization, or other appropriate diagnosis only after the case is reviewed with the treating physician and the physician prescribing Suboxone®/Subutex/Zubsolv®.

Note: Approval may be cancelled at any time if patient fails to comply with Treatment Plan: failure to establish with and attend counseling sessions; missed or inappropriate results from drug screens; breaking controlled substance/treatment contract.

Montana Medicaid
Suboxone®/Subutex®/Zubsolv®-PA Requirements
Physician Chart Check List

Patient Name:_____ Date of Birth:_____
Patient ID:_____

□ Copy of Assessment and Screening for Opioid Dependence (DAST-10, DSM-IV) or other supporting documentation

□ Opioid Substance(s) of Abuse _____

□ Psychosocial counseling referral made to_____
_____

□ Proposed counseling schedule* (weekly, q o week, etc) _____
_____

□ ***Patient informed that counseling is required. Documentation of active involvement in counseling must be submitted for continuation after initial month of therapy.***

□ Monitoring Plan (urine drug screens including buprenorphine and drugs of abuse, random pill counts, etc.)
_____
_____

□ Copy of treatment contract signed by patient

If female, is patient pregnant? Yes □ No □
If yes, documentation of a positive pregnancy test is attached if Subutex® requested Yes □ No □
Will patients OB care provider be contacted? Yes □ No □

****Recommend interface with provider to establish post-delivery plan for newborn (treatment of neonatal withdrawal syndrome). There are no adequate or well-controlled studies of Suboxone®/Subutex® in pregnancy (Cat C)**

OB Provider:_____ Date Contacted:_____
Phone:_____

This checklist is designed to aid the provider in completing the requirements necessary to obtain Prior Authorization for the use of Suboxone®/Subutex®/Zubsolv® through Montana Medicaid. All requirements herein may be faxed to the Montana Medicaid Drug Prior Authorization Unit at 1-800-294-1350 along with the Prior Authorization for Suboxone®/Subutex® Request Form.